STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155370	B. WI	B. WING			07/13/2023	
NAME OF F	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD			
	D	SE NEW () A DM () N			GHWAY 66			
PREMIEI	R HEALTHCARE C	OF NEW HARMONY		NEW H	ARMONY, IN 47631			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
F 0000								
Bldg. 00								
	This visit was for the	he investigation of complaints	F 00	000	Submission of this Plan of			
	IN00412806 and IN	N00412692.			Correction by the facility is not	a		
					legal admission that a deficien	су		
	Complaint IN00412	2806: No Federal/State			exists or that this Statement o	f		
	deficiencies are cite	ed related to the allegations.			Deficiencies was correctly cite	d.		
					In addition, preparation and			
	_	2692: Federal/state deficiencies			submission of this POC does	not		
	related to the allega	ations are cited at F600, F609,			constitute an admission or			
	and F740.				agreement of any kind by the			
					facility of the truth of any facts	set		
	Survey dates: July 12 & 13, 2023				forth in this allegation by the			
					survey agency. Please accep			
	Facility number: 00				following as the facility's credil	ole		
	Provider number: 1				allegation of compliance.			
	AIM number: 1002	267530						
	Census Bed Type:							
	SNF/NF: 63							
	Total: 63							
	Census Payor Type Medicare: 4	: :						
	Medicaid: 48 Other: 11							
	Total: 63							
	10(a): 03							
	These deficiencies	reflect State Findings cited in						
	accordance with 41	_						
	accordance with 41	0 II C 10.2-3.1						
	Quality review con	npleted on July 21, 2023.						
	Quality leview con	ipieted on July 21, 2023.						
F 0600	483.12(a)(1)							
SS=D	Free from Abuse	and Neglect						
Bldg. 00		rfrom Abuse, Neglect, and						
	Exploitation	· ···, · · · · · · · · · · · · · ·						
		the right to be free from						
		isappropriation of resident						
	,	11 1						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Janie Swedenburg Administrator 07/27/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIF	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>00</u>	COMPLETED	
		155370	B. WING		07/13/2023	
	PROVIDER OR SUPPLIER	F NEW HARMONY	STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION (X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREF		LD BE ROPRIATE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	G DEFICIENCY)	DATE	
IAU	property, and expl subpart. This inclifreedom from corpinvoluntary seclus chemical restraint resident's medical §483.12(a) The fa §483.12(a) (1) Not or physical abuse involuntary seclus Based on interview failed to ensure resion of 3 residents review increased behaviors services nor was the with a continuing ir resident to resident D), and prior to a sephysical altercation Resident C, Resident Finding includes: During a review of 7/12/23 at 10:00 A. included that a resident that a resident's room. Resident's room. Resident's room. Resident B's diagnol limited to dementia disturbance, insomr	loitation as defined in this udes but is not limited to boral punishment, ion and any physical or not required to treat the symptoms. cility must- use verbal, mental, sexual, corporal punishment, or ion; and record review, the facility dent were free from abuse for 1 wed for abuse. A resident with that not received psych the resident's care plan updated attervention following a physical altercation (Resident econd resident to resident (Resident C). (Resident B, and D) State Reportable Incidents on M., an incident, dated 6/29/23, dent was walking down the hall and turned to go in another sident B was in the room and the Resident D's face. Sew on 7/12/23 at 10:20 A.M., oses included but were not with other behavioral inia, and depression.	F 0600	1. The facility has take following corrective action address those residents a specifically identified as a A. Resident B shall be re-assessed for abuse ris return from the hospital. resident shall also be pla 1:1 monitoring to prevent future incidents until this has evidenced that they pose a risk for abuse that sustained and ongoing. It warranted, this resident resued an involuntary dissishould interventions and approaches fail to eliminate Resident B's potential to other residents. B. Resident C has been monitored by staff for any injury or negative outcom have been noted at this times.	en the n(s) to and areas affected: sk upon This ced on risk for resident no longer t is f may be charge ate abuse en / ongoing less. None time.	
	(Minimum Data Set	ecent quarterly MDS t) assessment, dated 6/23/23, nt's cognition was severely		The facility has ider residents with abusive be towards other peer residents.	ehaviors	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î î			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
		155370	B. W	ING		07/13/2023	
NAME OF T	DOMDED OF CURPLIES		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF			251 HI	GHWAY 66		
PREMIEI	R HEALTHCARE O	F NEW HARMONY	NEW HARMONY, IN 47631				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	Ŋ
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE	
	impaired.				having the potential to be at ri		
					for this alleged deficient practi	ce.	
		ian orders included but were			These residents shall be		
		t any unwanted behaviors from			re-assessed for abuse risk an		
	-	and as needed (started			their plans of care shall be au		
		mg (milligrams) for dementia			to ensure that interventions ar	nd	
		turbance (started 6/9/21), and			approaches are in place to		
	Zoloft 25 mg for de	pression (started 6/22/23).			address their behaviors.		
	Resident B's care pl	an included Resident is			Measures and systemat	c	
	-	ve due to anger and dementia			changes the facility has taken		
		. A new intervention, dated			correct this alleged deficient		
7/4/23, included, "15 minute checks." Prior				practice and ensure it does no	ot		
		dated, 11/28/23, and included			recur include:		
	that the resident bel	ieves people are stealing his					
		nt has behavior problem			A. Facility staff have been		
		nd" up frequently and			inserviced regarding the Facili	tv's	
		" (initiated 3/14/23). No			Abuse and Neglect policy.	´	
	-	ions were added following the			Specific discussion was given	to:	
		/23). Resident is verbally		reporting resident behaviors that			
		ed at another resident that			might pose risk to other reside		
		oor (initiated 6/12/23). No		to the DON and their appointed			
	-	ions were added following the			designee(s); utilizing effective		
	initiation date (3/14	_			interventions and approaches	to	
	,				de-escalate resident behavior		
	Resident B's progre	ss notes included but were not			safeguard other residents whe		
	limited to:				necessary (e.g. keeping other	I	
	6/29/23 at 3:59 P.M	I "This afternoon resident			residents away from agitated		
	swung fist at Reside	ent D in the hallway for			combative resident); and		
	_	Staff was able to intervene.			immediately reporting all		
	Residents are now s	separated."			allegations/instances of abuse	and	
		M "[Social Service Director]			neglect to the administrator		
		dent on this day regarding			(abuse coordinator) or the DO	N	
		sterday. Resident did not			when the administrator is		
		t did point out other resident			unavailable.		
		or] and told SSD to, "watch			B. The IDT has been		
	_	nt otherwise appeared to be in			in-serviced by the Administrat	or	
		spirits and doing well.			regarding the facility's abuse a		
	-	ate from other resident by			neglect policy with particular		
staff throughout the day."				emphasis placed on the issue	of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	00	COMPL	ETED
		155370	B. WING 07/13/2023			2023	
			ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.			SHWAY 66		
PREMIER	R HEALTHCARE O	F NEW HARMONY	NEW HARMONY, IN 47631				
(X4) ID	CLIMMADA	STATEMENT OF DEFICIENCIE	ID	, 1			(V5)
PREFIX		CY MUST BE PRECEDED BY FULL	PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION	TA		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	DATE
TAG		- "Resident was in hallway with	175	10	prevention and identifying		DAIL
		dent. Resident was witnessed			residents with behaviors that n	nav	
		le resident by the throat with			pose risk. Discussion was give	-	
		w her to the floor. CNA			the importance of preempting	511 tO	
		ted both residents. 911			situations via effective		
		transport to [hospital],			interventions and approaches	to	
		and updated and gave orders			prevent resident-to-resident	lo	
	to send to hospital f				altercations.		
	evaluation."	o up und			and out one.		
					4. The facility has impleme	nted	
	A 15 minute check	for 72 hour period check off			the following Quality Assurance		
	sheet, dated 6/30/23, indicated Resident B began				Plan to monitor on-going facilit		
	"15 minute checks" on 6/30/23 at 12:00 P.M. and				performance and compliance	-	
concluded on 7/3/23.				this requirement:			
					·		
	During an interview	on 7/12/23 at 1:20 P.M., the			1.The Administrator, DON a	nd	
	Activities Director	indicated that Resident B and			appointed designee(s) shall		
	Resident C had a no	on-romantic relationship, that			monitor abuse and neglect		
	Resident B had nev	er been aggressive toward			incidents/allegations to ensure	:	
	Resident C before a	nd had never been physically			that the facility's policy and		
	aggressive towards	other residents until he struck			procedures for Abuse and Neg	glect	
		3. The Activities Director			have been followed. This audit	t	
		s unclear as to why Resident B			shall occur for a minimum of s	ix	
		ent C on 7/6/23, but that			(6) months or longer until		
		ors had escalated prior to that			substantial compliance has be	en	
	incident.				achieved and is ongoing.		
		7/10/02 - 12 15 75 5			N		
	-	on 7/12/23 at 12:45 P.M., the			Noted problems shall be		
	· ·	Sursing) and ADON (Assistant			addressed immediately and		
	_) indicated that Resident B had			identified patterns/trends of	41	
		violent towards other			non-compliance shall be repor	ted	
	-	riking a Resident D, on			to the Quality Assurance		
		sident had entered a private B was in. On 7/6/23, Resident			Committee for further action(s).	
		grab Resident C by the throat					
	`	throw her to the ground.					
		nediately sent to the hospital					
		admitted to a Geri-Psych					
		the incident on 6/29/2, Resident					
		our monitoring period					
	D completed a /2 n	our monitoring period					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	ETED
		155370	B. WI	B. WING 07/13/2023			/2023
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	3			SHWAY 66		
PREMIEI	R HEAI THCARE O	F NEW HARMONY			ARMONY, IN 47631		
Themen in the state of the stat				Tu dinorti, int 17001		1	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	e checks that concluded on					
		ervention was added to					
	_	f care following the 72 hour					
	monitoring period.						
	During on internit	u on 7/12/22 of 11:05 A M. th-					
		v on 7/13/23 at 11:05 A.M., the when resident to resident					
	should be updated of	occur, residents plan of care					
	_	d be put into place to prevent					
	further incidents.	d be put into place to prevent					
	further merdents.						
	During an interview on 7/13/23 at 12:40 P.M., the						
	_	ursing) indicated that a					
		ald not admit a resident until					
		ke another individual (Resident					
		psych services following the					
		when he struck another					
	resident, and prior t	to him attacking Resident C on					
	7/6/23). At that tim	e, the Administrator indicated					
	that they believed to	he root cause of Resident B's					
	most recent behavio	ors had to do with Resident B					
	being over-protecti	ve of Resident C. The					
	Administrator indic	eated Resident C was moved off					
	of the secured demo	entia unit in attempt to stop					
		ssive behaviors, but that					
		iled due to Resident C					
		t the doors, and Resident C					
		nto the dementia unit. No new					
	new intervention w	as created following Resident					
	C's return to the un	it.					
	40.2-						
		P.M., the Facility Administrator					
		d facility policy titled, Policy					
		se Prevention. The policy					
		ents must not be subjected to					
		ncluding, but not limited to,					
	1	residents C. All staff will					
		d intervene in situations in					
	which abuse, negle	ct and/or misappropriation of					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155370		A. BUILDING B. WING	00	COMPI	COMPLETED 07/13/2023	
	PROVIDER OR SUPPLIER		251 H	T ADDRESS, CITY, STATE, ZIP COD IIGHWAY 66 HARMONY, IN 47631		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
F 0609 SS=D Bldg. 00	includes an analysis planning, and monit and behaviors which neglect, such as resi aggressive behavior. Protect residents fro investigation3. R accused will be assed Director and Nurse winch could include treatment, evaluation and/or psychologist, social service direct management/care plus behavior monitoring developed as appropriate appropriate of Allegy \$483.12(b)(5)(i)(A)(Reporting of Allegy \$483.12(c) (1) Ensional violations involving exploitation or misinjuries of unknown misappropriation or reported immediat hours after the allegevents that cause or result in serious than 24 hours if the	desidents a. The resident assed by the Social Service Manager for necessary action are referral for inpatient psych in by facility psychiatrist, or routine counseling by for b. Behavior an team will assess for a c. Care plan will be briate" B)(c)(1)(4) ates to complaint IN00412692. B)(c)(1)(4) ates to allegations of ploitation, or mistreatment, ure that all alleged a abuse, neglect, treatment, including in source and of resident property, are ely, but not later than 2 agation is made, if the the allegation involve abuse a bodily injury, or not later the events that cause the involve abuse and do not				

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Event ID:

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155370		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/13/2023			
	PROVIDER OR SUPPLIER R HEALTHCARE O		STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	officials (including Agency and adult state law provides care facilities) in a through established §483.12(c)(4) Repinvestigations to the resignated reposition of the resignated reposition of the state of the resignated reposition of the state of the resignated reposition of the state of the resident of the state of the reposition of the state of the reposition of the state of the resident of the resident of the resident was female resident. Regrab female resident was female resident. Regrab female resident was female resident of the resident of	port the results of all the administrator or his or presentative and to other ance with State law, ate Survey Agency, within the incident, and if the saverified appropriate must be taken. The and record review, the facility sident to resident physical ate agency in the required time ident to resident abuse. Following a reportable 3, the facility did not report the 23. (Resident B) We on 7/12/23 at 10:20 A.M., anotes included, 7/6/23 at 8:15 as in hallway with another sident was witnessed by CNA, the by the throat with both or to the floor. CNA ted both residents. 911 atransport to [hospital], and updated and gave orders	F 0609	1. The facility has taken the following corrective action(s) to address those residents and a specifically identified as affect. A. Facility management has been trained and educated regarding the facility's Abuse a Neglect Policy. Specific discussion was given to the requirement to report all allegations of abuse and neglet to the Department of Public Health, resident's representation resident's physician, ombuds office, and police if the incident/allegation gives rise to suspicion of a crime. B. Resident B shall be re-assessed for abuse risk upon return from the hospital. This resident shall also be placed of 1:1 monitoring to prevent risk future incidents until this residents evidenced that they no longer the same action of the same action	oreas ed: s and ect ve, nan o a on for ent	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155370		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 07/13/2023	
PROVIDER OR SUPPLIE R HEALTHCARE (R DF NEW HARMONY	251 HI	address, city, state, zip cod GHWAY 66 IARMONY, IN 47631		
SUMMARY (EACH DEFICIENT REGULATORY OF that staff had report that she was unable at that time. On 7/13/23 at 1:30 supplied an undate and Procedure Abust included, "Invest Reporting 1. The Annursing (in the abstract [state agent telephone or fax we alleged abuse, neglimisappropriation of the summary of	F NEW HARMONY T STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ted the incident to her, but te to report to the state agency P.M., the Facility Administrator d facility policy titled, Policy use Prevention. The policy tigation Purpose: A. Initial Administrator or Director of sence of the Administrator) will tey] and local ombudsman by tithin 24 hours to report all lect, involuntary seclusion or			be ge se going None ed iors as risk tice. Indudited and et to ot	
			abuse/neglect occurrences w the administrator is unavailab The management team has	ole.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155370			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/13/2023	
		100070	<u> </u>	ADDRESS SITE OF THE STREET	31710/2020
NAME OF F	PROVIDER OR SUPPLIEF	8		ADDRESS, CITY, STATE, ZIP COD GHWAY 66	
PREMIE	R HEALTHCARE O	F NEW HARMONY		ARMONY, IN 47631	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	inserviced regarding this new procedure. The administrator is also contact a member of the consultant team to ensure that procedures for abuse and neghave been followed. B. Facility staff have been inserviced by the Administrator regarding the Facility's Abuse Neglect policy. Specific discussion was given to: report resident behaviors that might risk to other residents to the Dand their appointed designee(utilizing effective interventions approaches to de-escalate resident behaviors and safeguother residents when necessar (e.g. keeping other residents a from agitated or combative resident); immediately reporting allegations/instances of abuse neglect to the administrator (abuse coordinator) or the DO when the administrator is unavailable. 4. The facility has implemente the following Quality Assurance Plan to monitor on-going facility performance and compliance in this requirement: 1.The Administrator, DON a appointed designee(s) shall monitor resident progress note and behavior documentation to ensure that all instances of possible abuse and neglect has	t all plect or and rting pose poN s); and paway away away ng all a and N nted be ty with nd es o

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Event ID:

YWTD11 Facility ID: 000555

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG <u>00</u>	COMPLETED		
		155370	B. WING	07/13/2023			
	PROVIDER OR SUPPLIE	R OF NEW HARMONY	STREET ADDRESS, CITY, STATE, ZIP COD 251 HIGHWAY 66 NEW HARMONY, IN 47631				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID)	(X5)		
PREFIX		NCY MUST BE PRECEDED BY FULL	PREI	PROVIDER'S PLAN OF CORRECTION			
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA		DATE		
				Public Health and have been handled in accordance with facility's Abuse and Neglect policy. This audit shall occu 24 (24) consecutive weeks longer until substantial com has been achieved and is on Noted problems shall be addressed immediately and identified patterns/trends of non-compliance shall be repto the Quality Assurance Committee for further actions.	the r for or oliance ngoing.		
F 0740 SS=D Bldg. 00	Each resident mumust provide the care and services highest practicable psychosocial well the comprehensive care. Behavioral resident's whole ewell-being, which to, the prevention and substance us Based on observation review, the facility healthcare needs for behaviors. Residen	ral health services. st receive and the facility necessary behavioral health to attain or maintain the e physical, mental, and -being, in accordance with re assessment and plan of health encompasses a emotional and mental includes, but is not limited and treatment of mental	F 0740	The facility has taken following corrective action(s address those residents and) to		
	resident behavioral	wing multiple resident to incidents, and a resident's of created following a diagnosis being ordered an		A. Resident B shall be re-assessed for abuse risk to			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLET			ETED	
		155370	B. WING 07/13/2023			2023	
				CTREET	ADDRESS SITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DDEME	D 115 41 7110 4 DE 0	E NEW LIADA ONLY			GHWAY 66		
PREMIE	R HEALTHCARE O	F NEW HARMONY		NEW H	IARMONY, IN 47631		
(X4) ID	D SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	antidepressant med	ication. (Resident B, Resident			return from the hospital. This		
	C)				resident shall also be placed of	n	
	,				1:1 monitoring to prevent risk		
	Findings include:				future incidents until this resident		
					has evidenced that they no lor		
	1. During a review	of State Reportable Incidents			pose a risk for abuse that is	3	
	_	A.M., an incident, dated			sustained and ongoing. If		
		nat a resident was walking			warranted, this resident may b	e	
	· ·	cked unit and turned to go in			issued an involuntary discharg		
		oom. Resident B was in the			should interventions and	•	
room and made contact with the resident's face.				approaches fail to eliminate			
					Resident B's potential to abus	е	
During record review on 7/12/23 at 10:20 A.M.,				other residents.			
	_	oses included but were not			B. Resident C has been		
	limited to dementia with other behavioral				monitored by staff for any ong	oina	
	disturbance, insomi	nia, and depression.			injury or negative outcomes. N	-	
	·	•			have been noted at this time.		
	Resident B's most r	ecent quarterly MDS					
	(Minimum Data Se	t) assessment, dated 6/23/23,			2. The facility has identified	l	
	indicated the reside	nt's cognition was severely			residents with abusive behavior		
	impaired.				toward other peer residents as	3	
					having the potential to be at ris		
	Resident B's physic	ian orders included but were			for this alleged deficient practi		
	not limited to; Char	t any unwanted behaviors from			These residents shall be		
	resident every shift	and as needed (started			re-assessed for abuse risk and	d	
	6/13/23), Aricept 5	mg (milligrams) for dementia			their plans of care shall be aud	dited	
	with behavioral dis	turbance (started 6/9/21), and			to ensure that interventions ar	ıd	
	Zoloft 25 mg for de	epression (started 6/22/23).			approaches are in place to		
					address their behaviors.		
	Resident B's care pl	lan included Resident is					
	physically aggressi	ve due to anger and dementia			3. Measures and systemati	С	
	(initiated 11/28/22)	. An new intervention, dated			changes the facility has taken	to	
	7/4/23, included, "	15 minute checks." Prior			correct this alleged deficient		
	interventions were	dated, 11/28/23, and included			practice and ensure it does no	t	
	that the resident bel	lieves people are stealing his			recur include:		
		nt has behavior problem					
	waking his "girlfrie	nd" up frequently and			A. The following measure h	nas	
	"obsessing over her	" (initiated 3/14/23). No			been taken: The IDT has beer		
	additional intervent	ions were added following the			inserviced by the Administrato	r	
	initiation date (3/14	4/23). Resident is verbally			regarding the importance of		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155370 B. WING 07/13/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 251 HIGHWAY 66 PREMIER HEALTHCARE OF NEW HARMONY NEW HARMONY, IN 47631 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE aggressive and yelled at another resident that monitoring resident behaviors and opened bed room door (initiated 6/12/23). No developing interventions and additional interventions were added following the approaches to avert behaviors with initiation date (3/14/23). the potential for injury to self or others. Detailed discussion was Resident B's progress notes included but were not given to continually revising limited to: interventions and approaches as 6/11/23 at 2:22 P.M. - Another resident opened needed to avert bedroom door and Resident B became agitated resident-to-resident altercations and got up and slammed the bedroom door and/or resident injury/harm to self yelling, "Get out and stay out." Nurse explained to or others. resident that she did not know any different and В. The following systematic he said, "I don't care keep her out." change has been implemented: 6/13/23 at 4:48 P.M. - "Resident was in dining The leadership team shall review area... and he walked up to another resident and resident behavior documentation started yelling at her. Resident was moved away during the morning team meeting from other resident, no other occurrences noted to identify possible resident during this shift. Received order for [lab work and behaviors that might require urinalysis with culture and sensitivity if revisions to the resident's plan of indicated]... for possible urinary tract infection care. (UTI). Will continue to monitor resident for any further behaviors." The facility has implemented 6/25/23 10:13 A.M. - "Another female resident was the following Quality Assurance trying to enter room resident was in. Resident Plan to monitor on-going facility trying to shut door on resident and closed fist and performance and compliance with put it up to female residents face. Did not strike this requirement: resident. Stated 'Get the hell out of my room!' Redirected female resident to dining room and 1.The Administrator, DON and brought [Resident B] his morning medications. appointed designee(s) shall Took without difficulty and was pleasant with this monitor resident behaviors to nurse." ensure that effective interventions 6/27/23 at 5:35 P.M. - "Resident was verbally and approaches are being aggressive with another resident. Was able to maintained and/or implemented to redirect resident and no further issues noted. Will prevent resident-to-resident continue to monitor." altercations or other risk for injury 6/29/23 at 3:59 P.M. - "This afternoon resident to self or others. This monitoring swung fist at other resident in the hallway for shall also monitor that plans of entering his room. Staff was able to intervene. care for affected residents are Residents are now separated." being revised and updated as 6/30/23 at 12:54 P.M. - "[Social Service Director] warranted. This audit shall occur

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039							
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155370	A. BUILDING B. WING	00	COMPLETED 07/13/2023		
		100070			0171072020		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
PREMIEI	R HEAI THCARE O	F NEW HARMONY	251 HIGHWAY 66 NEW HARMONY, IN 47631				
	T			1			
(X4) ID		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	COMPLETION DATE		
TAG		dent on this day regarding	IAG	for a minimum of six (6) mon			
		sterday. Resident did not		longer until substantial comp			
		t did point out other resident		has been achieved and is on			
	involved in [behavi	or] and told SSD to, "watch					
		nt otherwise appeared to be in		Noted problems shall be			
	_	spirits and doing well.		addressed immediately and			
		ate from other resident by		identified patterns/trends of			
	staff throughout the	-		non-compliance shall be repo	orted		
		- "Resident was in hallway with dent. Resident was witnessed		to the Quality Assurance Committee for further action(0)		
		le resident by the throat with		Committee for further action(5).		
		w her to the floor. CNA					
		ted both residents. 911					
	services notified for	transport to [hospital],					
		and updated and gave orders					
	to send to hospital f	or full work up and					
	evaluation."						
		for 72 hour period check off					
		3, indicated Resident B began on 6/30/23 at 12:00 P.M. and					
	concluded on 7/3/23						
	concluded on 7/3/2:	·					
	During an interview	on 7/12/23 at 1:20 P.M., the					
	Activities Director	indicated that Resident B and					
	Resident C had a no	on-romantic relationship, that					
		er been aggressive toward					
		nd had never been physically					
		other residents until he struck					
		3. The Activities Director lent B's behaviors had					
	escalated recently.	ent B's denaviors had					
	iscalated feechily.						
	During an interview	on 7/12/23 at 12:45 P.M the					
	_	Jursing) and ADON (Assistant					
	_) indicated that Resident B had					
		violent towards other					
	•	riking a resident on 6/29/23,					
		d entered a private room that					
	Resident B was in.	On 7/6/23, Resident B was					

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observed to grab Resident C by the throat in the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155370		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/13/2023	
	PROVIDER OR SUPPLIER R HEALTHCARE OF NEW HARMONY	251 HIC	ADDRESS, CITY, STATE, ZIP COD GHWAY 66 ARMONY, IN 47631		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	hallways and throw her to the ground. Resident C sustained a skin tear to her right elbow when she fell to the ground. Resident B was immediately sent to the hospital and had since been admitted to a Geri-Psych facility. Following the incident on 6/29/2, Resident B completed a 72 hour monitoring period including 15 minute checks that concluded on 7/2/23. No new intervention was added to Resident B's plan of care following the 72 hour monitoring period. During an interview on 7/13/23 at 12:40 P.M., the Facility Administrator indicated Resident B's plan of care had not included monitoring the resident following a new diagnosis of dementia and an order to receive antidepressant medication Zoloft (started 6/22/23), but that it had been added to the plan of care on 7/13/23. 2. During an observation on 7/12/23 at 9:45 A.M., Resident C was lying in bed in their room fully dressed. Resident C was pleasant during an interview at that time. The resident was alert with confusion. During record review on 7/12/23 at 10:20 A.M., Resident C's diagnoses included but were not limited to dementia with behavioral disturbance, and anxiety disorder. Resident C's most recent quarterly MDS, dated 6/9/23, indicated the resident's cognition was severely impaired. Resident C's physician orders included but were not limited to; Donepezil 10 mg for dementia with behavioral disturbance (started 5/18/21), and Zoloft (antidepressant) for dementia with behavioral disturbance (started 5/18/21), and Zoloft (antidepressant) for dementia with behavioral disturbance (started 12/3/22).				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DA			DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
155370		B. W	ING		07/13/	2023	
NAME OF B	NDOLUDED OD GLIDDLIE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	NAME OF PROVIDER OR SUPPLIER				SHWAY 66		
PREMIE	R HEALTHCARE C	OF NEW HARMONY		NEW H	ARMONY, IN 47631		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		plan included, resident has					
		ysically aggressive (swatting ted 2/25/22). No interventions					
		the plan of care since 5/30/23,					
		ent regarding Resident C hitting					
	another resident wi						
	Resident C's nurses	s notes included the following:					
	6/14/23 at 5:39 P.N	A "Resident was sitting in					
	dining room on Ca	rdinal Unit and another resident					
	_	next to this resident. Resident					
	-	rater and threw water towards					
		ident then got up from table					
	and went to her roo	om"					
	6/25/23 12:36 P M	"[Resident] in dining room					
		resident next to [Resident C]					
	-	stuff off her tray. Attempted to					
		ent, unsuccessful. Male					
		it again. [Resident C] became					
		ed and started yelling at male					
		C] took her tray and shoved it					
	at other resident. T	ray with food went all over					
	male resident and f	floor and plate broke. Staff					
	removed male resid	dent from situation to change					
	_	ent C] went down the hallway					
	to her room."						
	7/8/22 of 1.50 D M	"Heard another resident					
		Found in [Resident C's] room					
		ting her. When asked [Resident					
	_	resident. Stated 'Yes, I hit her					
	_	in. She needs to stop and get					
	_	aned to resident that this was					
	inappropriate beha						
	_	w on 7/13/23 at 11:05 A.M., the					
		when resident to resident					
		occur, residents plan of care					
	should be updated	or revised and new					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155370	B. WING		07/13/2023		
NAME OF I	E OF PROVIDER OR SUPPLIER EMIER HEALTHCARE OF NEW HARMONY D SUMMARY STATEMENT OF DEFICIENCIE IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION interventions should be put into place to prevent further incidents. On 7/13/23 at 1:30 P.M., the Facility Administrator			STREET A	ADDRESS, CITY, STATE, ZIP COD SHWAY 66 ARMONY, IN 47631 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	07/13/	
	supplied an undated facility policy titled, Behavior Management - Clinical Protocol. The policy included, "Assessment and Recognition4. For new and worsening behaviors, the nurse shall assess and document/ report the following:i. Any recent medication changes m. Interventions attempted to alleviate behavioral symptoms, both pharmacological and non-pharmacological 1. The staff will use protocols to identify pertinent interventions, other than medications, for the nature and causes of the individual's problematic behavior. Review 1. New and worsening behaviors will be reviewed by the IDT (intra-disciplinary team) the following business day for:f. New interventions targeted to the behavior h. updating of care plan Monitoring5. The nursing staff and the Physician will monitor for side effects and complications related to psychoactive medications" This Federal tag relates to complaint IN00412692.						

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